Children's Mental Health Needs Assessment in the Bronx

New York City Department of Health and Mental Hygiene
in Collaboration with
Mailman School of Public Health at Columbia University

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EXECUTIVE SUMMARY

The New York City Department of Health and Mental Hygiene's Division of Mental Hygiene (DMH) is committed to improving the planning and delivery of mental hygiene services in New York City. Toward this end, DMH conducted a needs assessment of child and adolescent mental health clinic services in the Bronx to address the following three aims:

I. To identify and describe service demand for outpatient mental health clinic services for children in the Bronx;

II. To identify the operational capacity for outpatient mental health clinic services for children in the Bronx; and

III. To identify the licensed capacity of outpatient mental health clinic services for children in the Bronx.

This needs assessment, which utilized a mail survey of 21 outpatient mental health clinic service providers, focuses on children who attempt to access care. It does not include children who may need services, but never attempt to access them. As such, this needs assessment focuses only on measurable demand and not the full scope of need for children's outpatient mental health clinic services in the Bronx.

Highlights of the findings, which are provided in greater detail in this report, include the following:

- Nearly 57% of the children who access outpatient mental health services were diagnosed with serious emotional disturbance (SED). Forty-one percent were diagnosed with attention deficit hyperactivity disorder, 20% with other disruptive behavior disorders, and 45% with co-occurring psychiatric disorders.

- From the point of referral to the beginning of treatment, the average length of time was about six weeks. From referral to initial intake appointment, children who sought services waited an average of 18 days. Intake generally involved two sessions that presumably occurred over a two-week time period. Upon completion of the intake process, there was an average wait of 13 days before the first treatment session.

- Less than half of the referrals for outpatient mental health services resulted in treatment. For every 100 referrals, 62 children attended an initial intake session. Of those, 47 completed the intake process. Of those who completed the intake process, 4 had their cases closed prior to any treatment sessions. Therefore, for every 100 referrals for outpatient mental health clinic services, 43, or less than half, continued on to treatment.

- The clinical staff vacancy rate was 6.5%. Average clinic turnover rates were 7.2% for salaried clinical staff and 10.8% for contract clinical staff. These findings suggest that

overall, operational capacity of the outpatient mental health clinics in the Bronx was close to licensed capacity**.**

- Spanish was the primary language of approximately 34% of the parents and 8% of the children served across clinics. Thirty-seven percent of the clinics had clinical staff whose bilingual ability was inadequate to serve Spanish-speaking parents/guardians.

- Ethnic differences existed between enrolled children and clinical staff in the Bronx. Although 94% of children were black or Hispanic, there was a greater proportion of white clinical staff compared to black and Hispanic clinical staff

- More than 85% of the enrolled children were covered by either traditional or managed care Medicaid. This finding indicates that most of the children served by outpatient mental health clinics in the Bronx are living in poverty.

- Nearly 18% of enrolled children were in the foster care system.

Taken together, these findings -- the severity and complexity of the diagnostic, functioning, and socio-demographic characteristics of the children, the extended average wait for services, and the attrition of children prior to treatment -- illustrate a problematic interface between service demand and service provision. Fifty-seven percent of referrals for outpatient mental health clinic services do not lead to treatment. It is unlikely that all of these referrals are for children who do not need treatment or are being treated elsewhere. Moreover, the finding that these clinics have low staff vacancy rates suggests that the licensed capacity of the system is inadequate. In summary, these findings depict a system that is not meeting the needs of children who are presenting for outpatient mental health clinic services in the Bronx.

INTRODUCTION

The New York City Department of Health and Mental Hygiene's Division of Mental Hygiene (DMH) is committed to improving the planning and delivery of mental hygiene services in New York City. One mechanism for doing so is through the collection and analysis of data to address specific programmatic and service delivery questions. Toward this end, DMH conducted a needs assessment of child and adolescent mental health clinic services in the Bronx to determine: the extent to which children and adolescents (hereafter referred to as "children") who try to access services are able to do so; the spectrum of illnesses that they present; the type and quantity of services they receive; and the licensed and actual capacity of outpatient mental health clinics to respond to the demand for care. As a secondary goal, DMH sought to test the feasibility of using a provider mail survey to conduct a needs assessment.

AIMS

This project had the following three aims:

I. To identify and describe service demand for outpatient mental health clinic services for children in the Bronx;

II. To identify the operational capacity for outpatient mental health clinic services for children in the Bronx; and

III. To identify the licensed capacity of outpatient mental health clinic services for children in the Bronx.

CHILDREN AND CLINICS IN THE BRONX

Service delivery for children seeking outpatient mental health services from licensed mental health clinics in the Bronx was selected as a focus of this needs assessment for two reasons: 1) there is a large population of children in the Bronx in proportion to its total population; and 2) reports from mental health providers and school personnel in the Bronx indicate that the services available are not sufficient for the population seeking them.

Based on the 2000 U.S. Census, the total population in the Bronx is approximately 1.3 million people of whom almost 30%, or 430,000, are children under 18 years of age. Most of the people who reside in the Bronx are Hispanic (48.4%) or African-American (35.6%). The median Bronx household income in 1999 was $27,611. Approximately 30% of the general Bronx population lived below the poverty line in 1999; however, a disproportionate number of them were children under the age of 18. Of the total population of 430,000 children under age 18 in the Bronx, 158,355, or nearly 37%, lived below the poverty line in 1999.

Twenty-one licensed mental health service providers offer outpatient mental health clinic services for children in the Bronx. In calendar year 2000, Medicaid payments to Bronx clinics for mental health services for children exceeded $16 million (New York State Office of Mental Health Medfisa Data, 2000). These mental health providers, which are listed below, represent a wide range of settings (e.g. hospital-based clinics, school satellite clinics, and community-based mental health clinics) and also vary widely in the numbers of clients they serve and the quantity of services they provide annually.

LICENSED OUTPATIENT MENTAL HEALTH SERVICE PROVIDERS IN THE BRONX

Astor Child Guidance Center

Bronx Lebanon Hospital Center

Bronx Mental Health Service of HIP

Catholic Charities Counseling Services

Federal Employment and Guidance Service (FEGS)

Hunts Point Multi-Service Center

Independent Consultation Center

Jacobi Medical Center

Jewish Board of Family and Children's Services (JBFCS)

Lincoln Medical and Mental Health Center

Montefiore Medical Center

Morris Heights Counseling Center

Morrisania Diagnostic and Treatment Center

New Beginnings

Our Lady of Mercy Medical Center

Puerto Rican Family Institute

Riverdale Mental Health Center

St. Barnabas/Fordham Tremont

Sound View-Throgs Neck Mental Health

South Bronx Mental Health Council

University Consultation and Treatment Center

METHODS

To address the objectives of this project, two primary methods were used: a mail survey of service providers and, as a validation tool, analysis of data from the 1999 New York State Office of Mental Health Patient Characteristics Survey. Further validation against encounter forms, billing data, clinic charts or personnel records was not conducted. Brief descriptions of each of these methods are provided below. Detailed information is provided in Appendix I.

MAIL SURVEY

A mail survey instrument, provided in Appendix II, for children's outpatient mental health clinics in the Bronx was designed to carry out this assessment. Details about the formulation of this survey are included in the methods section of Appendix I.

Twenty-one New York State Office of Mental Health-licensed agencies and hospitals that provide outpatient mental health clinic services[1] were identified. Surveys were sent in March 2003 to directors of all twenty-one agencies and hospitals; nineteen completed and returned the surveys, yielding a response rate of 90%. The 19 providers reported data for 26 service locations of which five were hospital-based outpatient clinics, 16 were community-based outpatient clinics and five were school-based satellite sites. Data was pooled across service locations for providers with more than one site or program. For simplicity, we define the entire complement of outpatient mental health clinic services for children offered by each provider as a "clinic."

Given that many of the findings are reported in aggregated mean percentages across clinics that vary widely in size, the means were adjusted to reflect the size of the clinics reporting. These adjustments were based on the estimated number of referrals received by each clinic, the number of children enrolled in services, and the number of clinical staff.

SECONDARY DATA ANALYSIS

Data from the 1999 New York State Office of Mental Health (OMH) Patient Characteristics Survey (PCS) (the most recent year for which completed data are available) were analyzed to obtain socio-demographic and diagnostic information for children seen during the PCS survey week in outpatient mental health clinics in the Bronx. This information was used to assess the validity of the information gathered in the provider mail survey.

[1] It should be noted that the following outpatient services were excluded from this survey: outpatient day treatment, crisis intervention, home and community based waiver, case management and after-school day programs.

FINDINGS

SERVICE DEMAND

Aim I: *To identify and describe service demand for outpatient mental health clinic services for children in the Bronx.*

In this needs assessment, service demand focused on the children presenting for outpatient mental health clinic services in the Bronx and their access to and utilization of services. To address service demand, the following domains were considered: client socio-demographic characteristics, diagnoses, and payment sources; referral, intake and treatment attendance (including average length of time for service provision); and reported gaps in the service delivery system.

SOCIO-DEMOGRAPHIC CHARACTERISTICS OF ENROLLED CHILDREN

- As of January 1, 2003, there were 6,546 actively enrolled children in the surveyed outpatient mental health clinics.
- More than 66% of the children were male. Approximately 60% were Hispanic, and 30% were black; less than 5% were white.[2]
- Spanish was the primary language of approximately 8% of the children and 34% of the parents, guardians, or primary caregivers.[3]
- More than 85% of the children were poor enough to qualify for Medicaid.
- Almost 18% of children were in the foster care system.
- Additional information is provided in Table 1 on the following page.

[2] These percentages are comparable to data collected by the 1999 Patient Characteristics Survey (PCS). In the 1999 PCS, 66% of clients were male; 62% were Hispanic; 32% were black; and 4% were white.
[3] In the 1999 PCS, 19% of the children primarily spoke Spanish. There is no PCS data available for primary language capability of parents, guardians, or primary caregivers.

TABLE 1. SOCIO-DEMOGRAPHIC CHARACTERISTICS OF ENROLLED CHILDREN

Socio-Demographic Characteristics	Percent of Clients*
Age Range[4]	
Under 5 years old	1.4
5-12 years old	62.6
13-17 years old	33.3
18-21years old	2.8
Gender	
Male	66.8
Female	33.2
Ethnic Background**	
White (not of Hispanic origin)	3.3
Black	30.9
Hispanic	62.5
Asian or Pacific Islander	0.5
Unknown	0.4
Primary Language-Child/Adolescent**	
English	90.5
Spanish	8.2
Unknown	1.1
Primary Language-Parent/Guardian/Primary Caregiver**	
English	65.4
Spanish	34.3
Unknown	0.2
Enrolled in Foster Care System	17.8

*Weighted mean percentages are based on reported number of clients enrolled in clinic as of January 1, 2003.

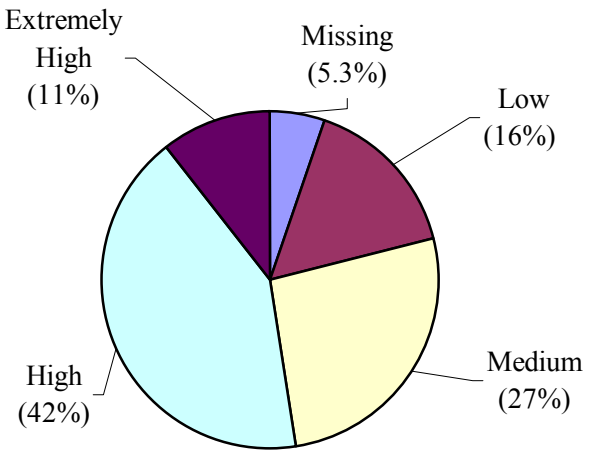
**May not total 100% as "other" category omitted from table.

[4] In the 1999 PCS, 0.9% of clients were under 5 years old; 72.7% were 5-12 years old; and 26.5% were 13-17 years old. PCS data for 18-21 year olds were not analyzed

DIAGNOSES OF ENROLLED CHILDREN

- Nearly 57% of enrolled children were diagnosed with serious emotional disturbance (SED)[5]. Clinics reported rates of SED ranging from 4% to 85%. The wide range reflects the diverse settings (e.g. hospital-based clinics, community-based mental health clinics, and school satellite clinics) and sizes of the clinics included in this needs assessment. The distribution of clinics reporting low (<25%), medium (26%-50%), high (51%-75%), and extremely high (>75%) proportions of clients with SED is provided below in Figure 1.

FIGURE 1. PERCENTAGE OF CLINICS REPORTING LOW, MEDIUM, HIGH AND EXTREMELY HIGH PROPORTIONS OF CLIENTS WITH SED

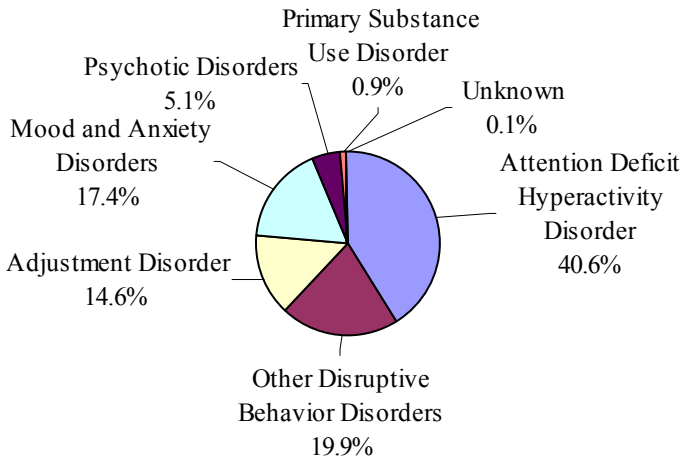


Total may not equal 100% due to rounding of percentages

[5] The survey mistakenly asked about "severe" emotional disturbance (SED). We assume the clinics understood that we intended to ask about "serious" emotional disturbance.

- The most commonly occurring psychiatric diagnosis among children was attention deficit hyperactivity disorder. Approximately 41% of the clients in the current survey were diagnosed with this disorder.[6] Additional information regarding the weighted mean distribution of diagnoses among enrolled children is provided below in Figure 2.[7]

FIGURE 2. DISTRIBUTION OF PRIMARY DIAGNOSES OF ENROLLED CHILDREN



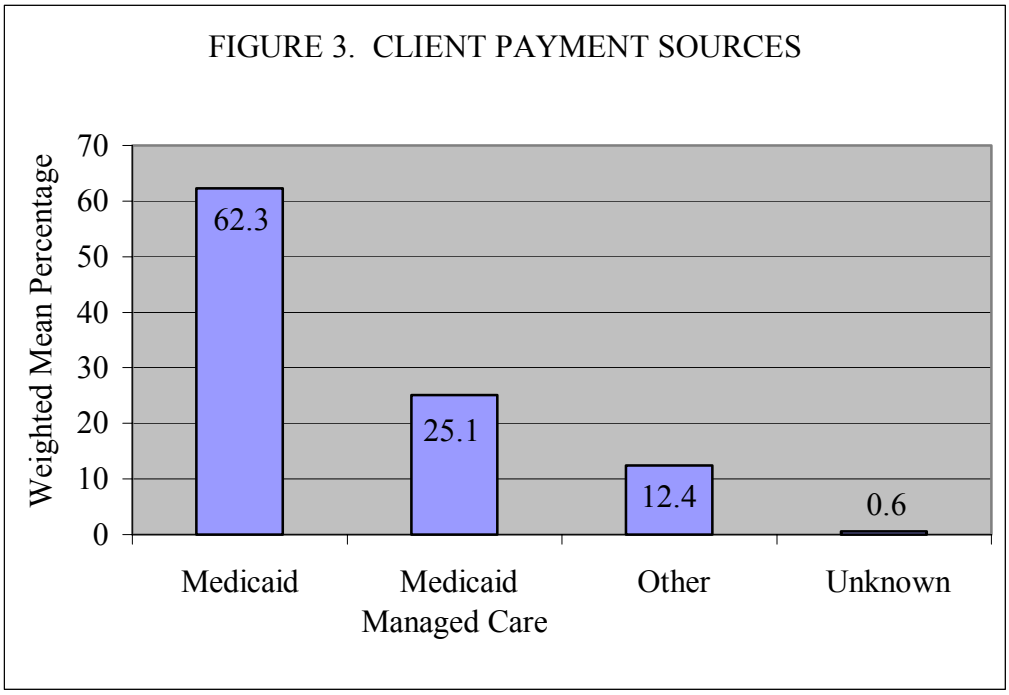
Weighted mean percentages are based on reported number of clients enrolled in clinic as of January 1, 2003.
May not total 100% as "other" category omitted from figure.

- Approximately 45% of child and adolescent clients were diagnosed with co-occurring psychiatric disorders.

[6] The 1999 PCS also reported that 41% of clients were diagnosed with attention hyperactivity disorder; and it was also the most commonly occurring psychiatric diagnosis.
[7] In the 1999 PCS, 14.0% of clients were diagnosed with other disruptive behavior disorders; 16.4% with adjustment disorder; 15.7% with mood and anxiety disorders; 3.6% with psychotic disorders; 0.2% with primary substance use disorder; and 5.4% were unknown or other.

PAYMENT SOURCES

- Most of the clients had Medicaid coverage. More than 60% were covered by traditional Medicaid, and 25% were covered by Medicaid managed care. See figure 3 below.



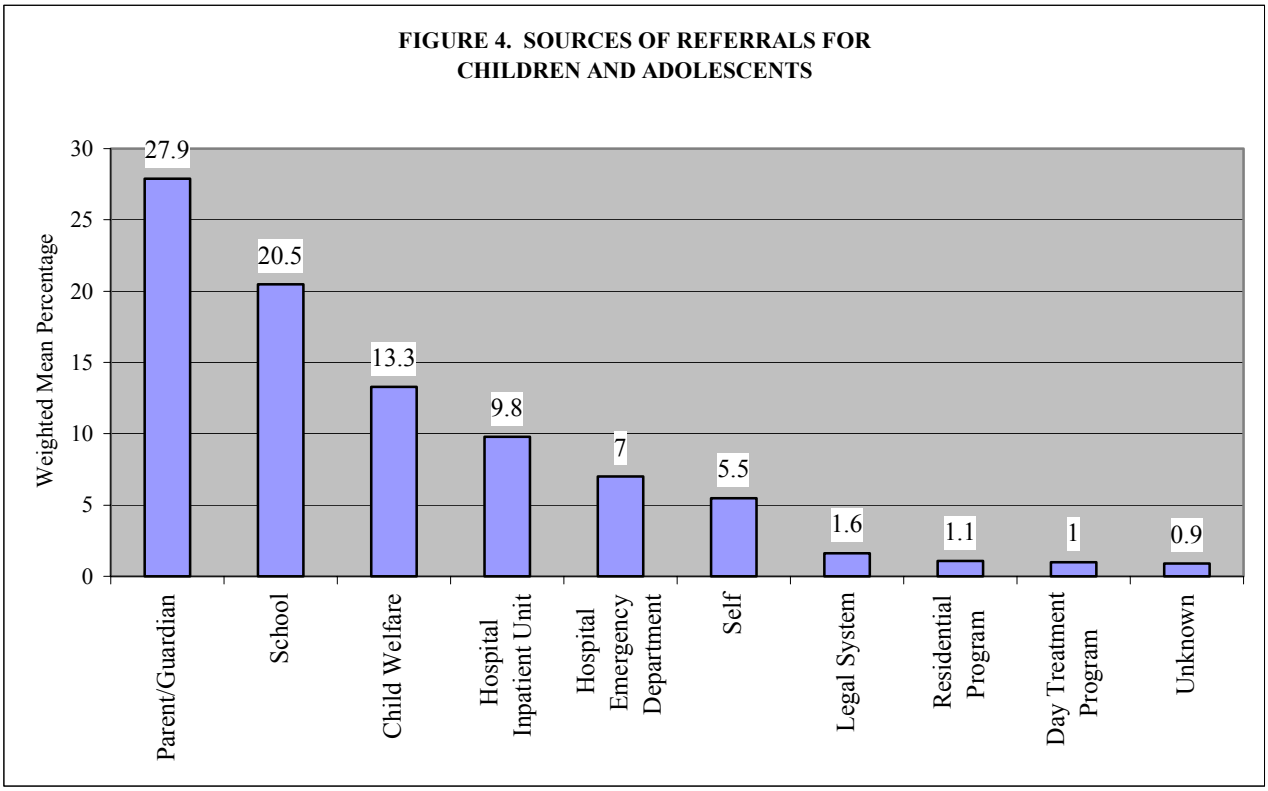
Weighted mean percentages are based on reported number of clients enrolled in clinic as of January 1, 2003.

REFERRAL

- The 19 clinics that responded to the survey received more than 12,600 referrals of children seeking outpatient mental health clinic treatment services during 2002.

- Twenty-eight percent of the referrals were made by parents/guardians, 21% by schools, 13% by child welfare, and 10% by hospital inpatient units. Additional information is provided in Figure 4 on the next page.

FIGURE 4. SOURCES OF REFERRALS FOR CHILDREN AND ADOLESCENTS



Weighted mean percentages are based on the estimated number of referrals during calendar year 2002.
May not total 100% as "other" category omitted from figure.

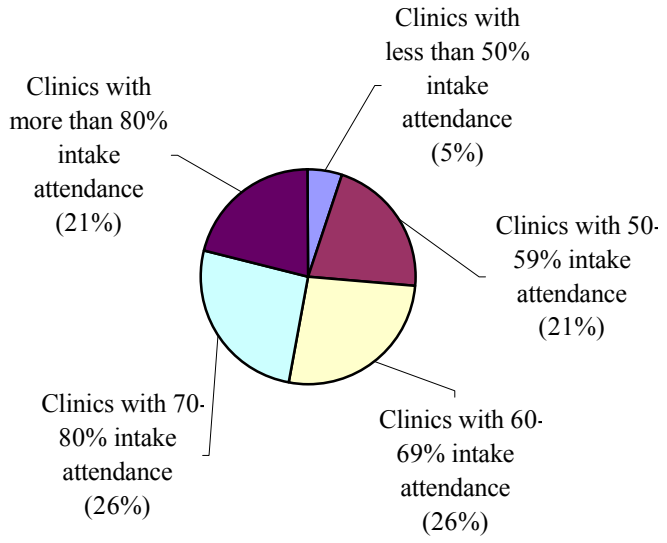
- Five percent of referrals were for children whose insurance was not accepted by the clinic, and 4% for children with no insurance at all. Children whose insurance was not accepted were most frequently referred back to their insurance plan, although temporary services were sometimes provided. Children without insurance were often treated on a sliding fee scale or encouraged to apply for publicly subsidized insurance (e.g. Medicaid or Child Health Plus).

- Providers reported that 4.8 % of referrals did not result in intake appointments. However, it should be noted that this estimate is likely to be low, since those children who were not eligible for services (such as those with primarily substance abuse problems and/or mental retardation/developmental disabilities) were not consistently included in this estimate. Among the referrals that did not result in intake appointments, 60% were for children who could be better served by another program, 17% for children with insurance not accepted by the clinic, and .4% for children without insurance. In 8% of cases, referred children were turned away because the clinic lacked capacity.

INTAKE

- Approximately 62% of referrals resulted in attendance at an initial assessment/evaluation appointment. Attendance rates across clinics ranged from 35% to 95%. Additional information regarding the distribution of attendance rates is provided below in Figure 5.

FIGURE 5. DISTRIBUTION OF ATTENDANCE RATES FOR INITIAL ASSESSMENT/EVALUATION



Total may not equal 100% due to rounding of percentages.

- The average waiting period from the date of initial contact with the clinic to the date of the initial evaluation/assessment was 18 days. However, this waiting period varied widely across clinics, ranging from 2 to 90 days. More than half (68%) of the clinics reported that their average wait was 21 days or more.

- Initial evaluation/assessment typically occurred in 2 sessions, with a range of 1 to 3.

- On average, 76% of those who began the intake process completed it. Once the intake process was completed, children who had been accepted for clinic services waited approximately 13 days for treatment to begin.

TREATMENT ATTENDANCE AND DISCHARGE

- Clinics reported an average no-show rate of 28% for scheduled treatment appointments.
- Approximately 9% of children were discharged prior to a single session of treatment; approximately 65% completed 8 or more sessions prior to discharge.
- Most discharges from services occurred because the child/family stopped attending services (46.9%) or because service goals were attained (34.3%).

NEEDED SERVICES

- In response to the question, "What services do your child and adolescent clients need, but cannot get, either from your program or elsewhere?" respondents most frequently identified day treatment and residential care. Eighty-nine percent of respondents identified the lack of these services, along with inpatient treatment, as among the five greatest challenges they face in providing care, see Table 2 below.

TABLE 2. PROVIDER-IDENTIFIED SERVICES CLIENTS NEED, BUT CANNOT GET*

Type of Service	Percentage of Clinics that Identified This Service
Day Treatment	95
Residential Care Facility	84
Inpatient Treatment	42
Mentoring Program (Big Brother, Big Sister)	37
After-school Activities	37
Psychological Testing	32
Educational	26
Family	21
Transportation	21
Medical	16
Vocational	11
Legal	11
Financial	5
Aftercare	5

*Across all service types, except aftercare, missing responses from 1 clinic (4.8%); aftercare missing responses from 2 clinics (9.5%).

OPERATIONAL CAPACITY

Aim II: To identify the operational capacity for outpatient mental health clinic services for children in the Bronx.

The identification of the operational capacity for outpatient mental health clinic services focused on the following domains: billable sessions provided, types of services provided, clinical staff turnover rates, Spanish-English language capability and ethnicity of clinical staff.

BILLABLE SESSIONS PROVIDED

- Overall, clinics reported conducting more than 161,000 billable sessions per year. But, the annual number of billable sessions varied widely among clinics, from 238 to 31,385. As described previously, the wide range reflects the diversity of the clinic settings and sizes. Additional information regarding the distribution of billable sessions is provided in Table 3 below.

TABLE 3. DISTRIBUTION OF BILLABLE SESSIONS AMONG OUTPATIENT MENTAL HEALTH CLINICS

Number of Billable Sessions Provided	Percentage of Clinics that Provided Services
Under 1,000	21
1,000-4,999	21
5,000-9,999	21
10,000-14,999	27
More than 15,000	11

TYPES OF SERVICES PROVIDED

- In compliance with New York State OMH licensing requirements for clinic treatment programs serving children (Regulation Code: 587.9), all of the providers in this needs assessment reported providing assessment/evaluation, individual psychotherapy, and psychopharmacology. See Table 4 below.

TABLE 4. REPORTED OUTPATIENT MENTAL HEALTH SERVICES PROVIDED FOR CHILDREN

Service Type	Proportion of Clinics Providing This Service
Assessment/Evaluation*	100
Individual psychotherapy*	100
Psychopharmacology*	100
Family Therapy	100
Group Therapy	90
Parent Skills Training	79
Case Management	63
Psychological Testing	74
School-Based Services	32
Home-Based Services	5
Other (Includes: collateral support, psycho-education, consultation to other providers, therapeutic nursery, court testimony)**	29

*Required outpatient clinic services for children (per Regulation Code 587.9).
**67% of clinics missing response for "other" category on this item.

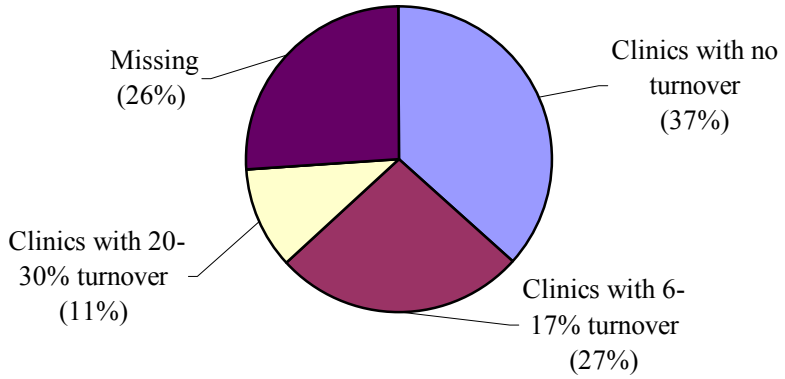
CLINICAL STAFF TURNOVER RATES

- Clinics reported average staff turnover rates for salaried and contract clinical staff of 7.2% and 10.8%, respectively.[8] While more than one-third of clinics reported no turnover in their salaried clinical staff, almost 11% of clinics reported turnover rates of 20% or more among salaried clinical staff. Additional information regarding the distribution of turnover rates among the clinics in this survey is provided below in Figure 6.[9]

[8] Turnover rates for salaried and contract clinical staff for each clinic were obtained from calculations using the following formula: the total number of salaried or contracted individuals who ended employment with the program in calendar year 2002 divided by the total number of salaried or contracted individuals employed in calendar year 2002.

[9] These turnover rates are lower than those reported for fiscal year 2000 by a recent publication of the Coalition of Voluntary Mental Health Agencies (CVMHA). The CVMHA findings are not comparable with the current findings due to numerous differences in sampling, definitions of constructs, and methodology.

FIGURE 6. DISTRIBUTION OF SALARIED TURNOVER RATES ACROSS CLINICS



Total may not equal 100% due to rounding of percentages.

SPANISH-ENGLISH LANGUAGE ABILITY

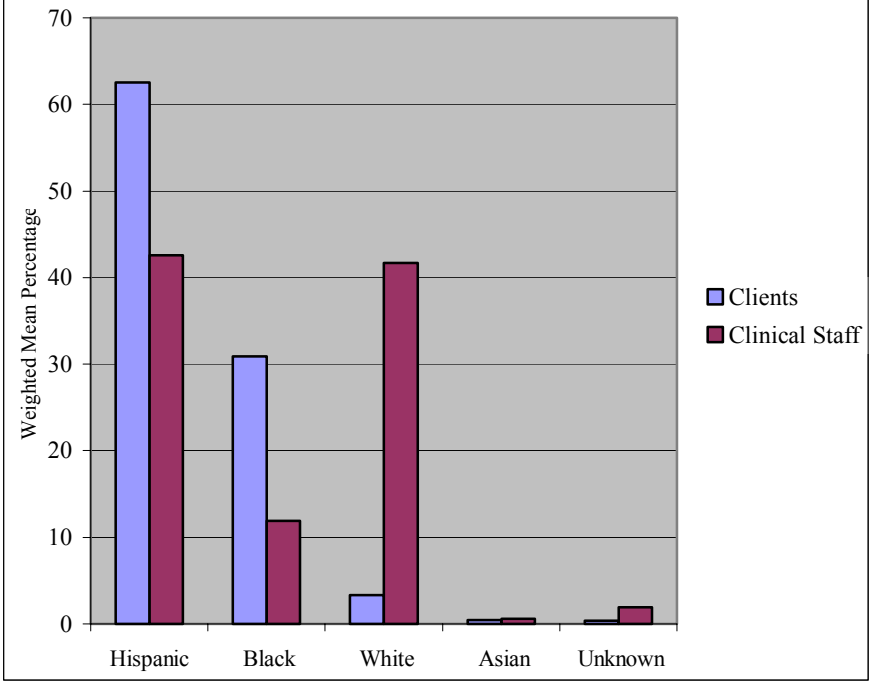
- Within each clinic, the proportion of bilingual clinical staff was similar to or exceeded the proportion of Spanish-speaking children enrolled in outpatient mental health clinic services.

- When the proportion of bilingual staff was compared to the proportion of Spanish-speaking parents/guardians in each clinic, 37% of the clinics reporting this information had inadequate bilingual capacity (16% of clinics reported insufficient information for analysis). Among the clinics with inadequate bilingual capacity, the mean difference between the proportions of Spanish-speaking parents/guardians and bilingual clinical staff was 12% (range 1% to 26%)

RACE/ETHNICITY

- There were numerous differences in race/ethnicity between enrolled children and clinical staff in the Bronx, as displayed below in Figure 7. Only 3% of all Bronx clients were white, in comparison to 42% of the clinical staff. Nearly 31% of the clients were black, in comparison to nearly 12% of the clinical staff. While there was less of a gap among the Hispanic providers, differing proportions still exist, with approximately 63% of clients and 43% of clinical staff being Hispanic.

FIGURE 7. RACE/ETHNICITY OF CLIENTS AND CLINICAL STAFF ACROSS CLINICS



Weighted mean percentages are based on reported number of clients enrolled in clinics as of January 1, 2003 and on reported number of clinical staff.

LICENSED CAPACITY

Aim III: To identify the licensed capacity of outpatient mental health clinic services for children in the Bronx.

BUDGETED AND ACTUAL CLINICAL STAFF

- Overall, there were 37.25 full-time equivalent (FTE) physicians, 164.49 FTE Master's and above clinical staff, 8.40 FTE paraprofessional clinical staff, and 6.75 FTE other clinical staff budgeted among the clinics that provided this information.

- Among the clinics that provided this information, there was a budgeted total of 217 FTE clinical staff and an actual total of 203 FTE clinical staff providing mental health services for children. This discrepancy between budgeted and actual staffing represents a 6.5% overall vacancy rate.

- Salaried physicians (most likely child psychiatrists) had a 7% vacancy rate, and Master's level and above clinical staff had a 6% vacancy rate.

- Most of the clinics are budgeted for one to two salaried physicians (47.6%), and for greater than five, and greater than 10 salaried Master's level clinicians (32% each respectively).

TABLE 5. BUDGETED SALARIED CLINICAL STAFF*

Full Time Equivalent Staff	Percent of Clinics Reporting Each Quantity of Budgeted Salaried Clinical Staff			
	Physicians	Master's and Above Clinicians	Paraprofessionals	Other Clinical Staff
< 1	16	0	74	79
1-2	48	11	16	11
>2-5	32	21	5	5
>5-10	0	32	0	0
> 10	0	32	0	0

*Full-time equivalent equals one staff member working at least 35 hours per week. If any staff worked in more than one staff category listed, respondents were asked to put them in the one category in which they worked the most during the week ending January 10, 2003. There is missing data from 1 clinic (4.8%). Due to rounded numbers total may not equal 100.

DISCUSSION

The findings presented here and their implications should be considered in the context of the strengths and limitations of this project. This project demonstrated the feasibility of conducting a provider mail survey. The 19 clinics that responded (of 21 contacted) have more than 6,500 children enrolled in their outpatient mental health services and more than 200 full-time equivalent clinical staff. The project's success at gathering information related to this many clients and clinical staff suggests that this methodology is effective for gathering aggregated information. The feasibility of this methodology is further demonstrated by our 90% response rate, especially in light of the length and complexity of the survey instrument (see Appendix II).

This project relied upon self-reported data from outpatient mental health clinics. Many of the clinics did not rely on "hard" data because of limitations in their data management systems or because they do not routinely collect the information requested in the survey. Consequently, many of the figures are based on "best estimates" made by clinics, and numerous variables had missing data. Confidence in the clinics' "best estimates" is strengthened by the consistency of selected estimates with data from the 1999 Patient Characteristics Survey.

As described previously, this project focused solely upon outpatient mental health clinic services and the provider perspective. Agencies that provide services in other settings may present different issues, as might parents, children, educators or advocates. Additionally, our focus on clinic-level data meant that we did not examine the experience of individual children. Further, this needs assessment focused on children who attempted to access care and did not include children who may have needed services but never attempted to access them. As such, this project focused only on measurable demand and not the full scope of potential need for children's outpatient mental health clinic services in the Bronx.

This needs assessment yielded several noteworthy findings regarding children's mental health clinic services in the Bronx. First, the diagnostic complexity and severity of the children enrolled in mental health clinics in the Bronx were significant. According to the respondents, approximately 57% of the children enrolled in services had serious emotional disturbance. Attention deficit hyperactivity disorder was diagnosed among 41% of the children. Another 20% were diagnosed with other disruptive behavior disorders. These two categories alone represent nearly two out of three children being seen for outpatient clinic services. Co-occurring psychiatric disorders occurred in 45% of the children. Additionally, nearly 90% of the children were covered by Medicaid and close to 20% were in foster care. The severity of emotional and behavioral symptoms, in conjunction with significantly impaired functioning and a high prevalence of poverty and foster care involvement, underscore the complexity of issues faced by this group of children, their families, and the clinics serving them.

Another significant finding was the length of time to the start of treatment and the amount of attrition prior to commencing treatment services. The survey found that an average wait to begin treatment was about six weeks from the initial application for services. Considering the large percentage of children experiencing serious emotional disturbance, this wait is unacceptably long. The average attrition rate of approximately 57% of referred children prior to treatment also

requires further attention. This means that for every 100 referrals, 62 children attended an initial intake session. Of those, 47 completed the intake process. Of those who completed the intake process, 4 had their cases closed prior to any treatment sessions. Therefore, for every 100 referrals for outpatient mental health clinic services, 43, or less than half, received any treatment. There are numerous reasons why some children do not complete the intake process or have their cases closed prior to treatment, including: they do not need the service, they are referred elsewhere for more appropriate services, or there are numerous barriers to their accessing care. We need to better understand the obstacles to obtaining treatment.

Once children begin treatment, approximately 65% attended eight or more sessions prior to discharge. Since the majority of children continued in treatment for eight or more sessions once engaged, we also need to focus our attention on preventing attrition prior to the commencement of treatment.

This project identified an overall clinical staff vacancy rate of 6.5% and clinic turnover rates of 7.2% for salaried clinical staff and 10.8% for contracted clinical staff. These overall rates were lower than expected and seem to indicate that staff vacancies and high turnover rates are not significantly limiting the operational capacity of clinics. In other words, it appears that operational capacity is close to licensed capacity. It should be noted, however, that these rates reflect overall staffing and do not address difficulties hiring specific categories of staff (e.g., psychiatrists, social workers, psychologists). Moreover, aggregated turnover rates may not adequately convey the type and impact of clinical staff turnover. Seventy-four percent of clinics identified staff recruitment and retention among the top five challenges they face. One respondent described the difficulty of recruiting child psychiatrists and the even greater difficulty of recruiting bicultural and/or bilingual staff. Recruitment and retention problems at the clinic level can be experienced as a troubling phenomenon and may not be best captured by the averages reported here.

The reported findings indicate that 37% of the clinics that provided complete information regarding language ability lacked adequate bilingual ability among their clinical staff to serve the proportion of parents/guardians who are Spanish-speaking (16% of respondents were missing this information). Implications of this finding may include limitations in performing family-oriented assessment and intervention and the potential for sub-optimal care or role confusion when children (and other family members) become translators and indirect conduits of information between parents/guardians and clinical staff. Additionally, differences between the proportional race/ethnicity of enrolled children and clinical staff were identified, although the extent to which racial and ethnic differences influence treatment retention or outcomes in these clients is not known.

Clinics most frequently identified day treatment and residential care as services their clients need but that their programs were unable to access. While this finding was consistent with anecdotal reports regarding needed services in the Bronx, several issues remain unclear, including the number of children needing these services, and the current capacity and timeliness of access to these services.

Taken together, these findings -- the severity and complexity of the diagnostic, functioning, and socio-demographic characteristics of the children, the extended average wait for services, and the attrition of children prior to treatment -- illustrate a problematic interface between service demand and service provision. Children seen in the Bronx clinics are predominantly Hispanic and African-American, living in poverty with high levels of serious emotional disturbance and disruptive behavior disorders. Almost one-fifth of them are in the foster care system. More than half of referrals for outpatient mental health clinic services do not lead to treatment, and many of the referrals lead to delayed treatment. Moreover, the reported low staff vacancy rates suggest that the licensed capacity of the system is inadequate. In summary, these findings depict a system that is not adequately meeting the needs of children who are presenting for outpatient mental health clinic services in the Bronx.

CITED REFERENCES

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Appendix I
Methods

DETAILED METHODS

A. MAIL SURVEY

A mail survey instrument for children's outpatient mental health service providers in the Bronx was formulated based on the study aims. Several questions were drawn from The National Center on Addiction and Substance Abuse at Columbia University study, "National Evaluation of Substance Abuse Treatment (NESAT)" and from a Ryan White Needs Assessment. Additionally, the NYC-DOHMH Children's Needs Assessment in the Bronx (CNAB) Project Team formulated others. The team worked on the survey by consensus agreement. When mailed to providers, the survey included a cover letter from Executive Deputy Commissioner, Dr. Lloyd Sederer and Assistant Commissioner, Dr. Louis Josephson, an instruction page, and a postage-provided return envelope. The survey and the accompanying materials are provided in Appendix II.

SAMPLE

Clinic directors received a survey if they provided, or were thought to provide, licensed outpatient mental health clinic services for children and adolescents in the Bronx, as defined by Regulation Number 587.9. Outpatient mental health services included individual, family, and group therapy. Excluded from the survey were outpatient day treatment, crisis intervention, case management, and after-school programs.

At the outset of this project, a current, complete listing of licensed outpatient mental health clinics in the Bronx did not exist. In order to identify all of New York State Office of Mental Health (OMH)-licensed outpatient mental health clinics in the Bronx, the CNAB project team consulted several sources, including the NYC DOHMH Bronx Borough Office, data maintained by the DMH Bureau of Planning, Evaluation and Quality Improvement, and the May 2000 Bronx Borough Office publication, "Bronx Children and Adolescents Mental Health Services." Phone screenings were conducted with numerous OMH-licensed providers to determine their eligibility for participation. Twenty-one OMH-licensed agencies and hospitals were ultimately identified as eligible for participation in this project.

Because this project aimed to assess children's outpatient mental health services in the Bronx as comprehensively as possible, the initial sample included New York State Office of Mental Health-licensed providers, as well as Administration of Children's Services foster care and preventive programs which were thought to provide outpatient mental health services for children. Through contact with Administration of Children's Services, we were provided with a list of preventive programs in the Bronx and of foster care agencies throughout New York City. Phone screenings conducted with a sample of the prevention programs indicated that these programs consistently provided outpatient mental health services to their clients. The project team decided to send surveys to all of the prevention programs. A total of 35 surveys were sent to ACS-funded prevention programs.

Because many of the foster care programs located throughout New York City provide services in the Bronx, an extensive phone screening was undertaken. Of the 54 foster care programs located throughout NYC that were contacted, 15 provided services, including outpatient mental health

services for children and adolescents, in the Bronx. Mail surveys were sent to each of these programs. However, based on a low response rate among the ACS foster care and prevention programs (10%) and questionable applicability of the survey for ACS providers, their responses are not included in this report.

Although it was initially planned that Department of Juvenile Justice (DJJ) would also be included in the mail survey, upon further investigation, it was learned that DJJ does not provide outpatient mental health services for children or adolescents in the Bronx. Thus, there were no DJJ-funded programs included in the survey.

RESPONSE RATE

Of the twenty-one New York State Office of Mental Health-licensed agencies and hospitals to which surveys were mailed in March 2003, nineteen completed and returned the surveys, yielding a response rate of 90%. Two additional OMH-licensed agencies were mailed and returned the survey, but their program types did not meet the inclusion criteria for the project. It should be noted, that in order to facilitate completion of the survey, providers were instructed to complete it for the unit size which was most applicable for them (i.e. providers with numerous programs and/or locations had the option to aggregate information across programs and to complete a single survey or to complete separate surveys for each program within the clinic). Thus, across the nineteen participating providers, twenty-one surveys were returned. In preparing the data for analysis, data were aggregated within clinics so that each clinic was represented only once in the analysis.

DATA ANALYSIS

Given the scope and aims of this project, data analysis focused on descriptive, univariate statistics. Since many of the findings are reported in aggregated mean percentages across agencies with wide variations in size, the means were often weighted based on the estimated number referrals, the number of children enrolled in services, or the number of staff.

The information gathered focuses on aggregated administrative data regarding funding, structure, and availability of and demand for outpatient mental health services for this population. No information regarding individual clients was gathered.

B. SECONDARY DATA ANALYSIS

Data from the 1999 New York State Office of Mental Health Patient Characteristics Survey (PCS) (the most recent year for which completed data are available) was analyzed to obtain socio-demographic and diagnostic information for children seen in the PCS survey week in outpatient mental health clinics in the Bronx. This information was used to compare and to validate the information gathered in the current mail survey. Billable sessions, enrollment and retention rates were not validated against encounter or billing forms or clinic charts; nor were staff vacancy and turnover rates validated against personnel records.

INVOLVEMENT WITH HUMAN SUBJECTS

The survey/interview component of the project involved clinic directors for children's outpatient mental health services in the Bronx. Information gathered addressed aggregated administrative data; no identifying information was gathered regarding individual clients. Upon consultation with the New York City Department of Health and Mental Hygiene's Institutional Review Board, we were advised that this type of needs assessment, which falls under the NYC DOHMH public health responsibilities and aims to be of benefit to providers and clients through improved planning information, did not require IRB review.

The secondary data analysis did not include direct contact with human subjects and included the analysis of data without identifying information.

Appendix II
Survey Materials

INTRODUCTORY LETTER

March 14, 2003

Provider Name
Provider Address
Bronx, NY

Dear Provider,

Our Department is embarking on a needs assessment of child and adolescent mental health services in New York City. This is part of our commitment to strengthen our capacity to plan for mental health services in the City. We have selected the Bronx as our initial site for this effort.

The Department's Division of Mental Hygiene Bureau of Planning, Evaluation and Quality Improvement along with the Office of Child and Adolescent Services of the Division will be conducting the needs assessment of children's mental health services. This assessment starts with outpatient child services, though we recognize that other service areas also greatly warrant our attention. We believe that what gets measured, gets managed. We are attaching a survey with instructions to be completed by the person most familiar with the clinical services. We will use the information we gather to work to improve services for this priority population in need.

We need your help to succeed. We need your cooperation in completing this survey, which aims to elicit your knowledge of the critical issues facing regarding children's outpatient mental health services. If you have any questions about this project, please feel free to contact Malitta Engstrom, Ph.D. at 212-342-0409. Thank you.

Sincerely,

Louis Josephson, Ph.D.
Assistant Commissioner
Office of Child and Adolescent Services

Lloyd Sederer, M.D.
Executive Deputy Commissioner
Mental Hygiene Services

INSTRUCTIONS COVER LETTER

Thank you for completing this survey and for taking part in the Children's Needs Assessment in the Bronx. We estimate that it will take approximately two hours of staff time to gather requested information and to complete this survey. The survey sections should be completed by the person who is best able to answer the questions. Please include all on-site and satellite programs which provide outpatient mental health services to children and/or adolescents.

If you oversee more than one program within your agency, you may have received numerous copies of this survey. If it is easier for you to complete one survey for all of the programs you oversee, please note for which programs you are completing the survey on the cover page. If it is easier for you to complete one survey for each of the programs you oversee, please use each of the copies you received.

If you only received one copy of the survey and you plan to make additional copies for additional programs within your agency, please change the survey number on the top of each page. If your original program survey is "Survey Number: 25," please change subsequent copies for each additional program to "Survey Number: 25a" for the first additional program, "Survey Number: 25b" for the second additional program, etc. In the event that pages get separated, this numbering system will help us be sure that we have a complete survey from each program. If you would like us to provide additional copies of the survey for you, please let us know.

Because we are hoping to gather information which is as accurate as possible, please rely on the most accurate data you have available. For a question where actual data are not available, please make your best-estimated response and mark that response with an asterisk (*).

If you come to a question that does not apply to your setting, please mark "does not apply" on the survey.

Neither you, nor your program, will be specifically identified in the discussion of findings from this project. Findings will be reported in the aggregate and will be used to inform children's mental health policy and planning.

We ask that you complete the survey, retain a copy for your records, and mail it back to us in the enclosed envelope or fax it back to us at 212-219-5627 by April 4, 2003. We will contact you by phone if we have any questions about your survey and/or if we need to clarify any information. Please feel free to contact Malitta Engstrom, Ph.D., at 212-342-0409 or Rufina Lee, M.S.W., at 212-342-0246, if you have any questions.

Again, we appreciate your participation. Thank you.

MAIL SURVEY INSTRUMENT

Program Information

Name of Agency:_____

Program Name:_____

Program Address: _____

_____

Program Phone: _____

OMH Facility Code, if Applicable:_____

OMH Unit Code, if Applicable:_____

Name of Person Completing this Form:_____

Phone Number for Person Completing this Form:_____

Title of Person Completing this Form:_____

Which of the Following Categories Best Describes this Program?

☐ OMH-Licensed Outpatient Mental Health Clinic

☐ ACS - Foster Care Agency

☐ ACS - Prevention Agency

☐ Other (Please specify):_____

Days and Hours of Program Operation: _____

_____

_____

I. Program Background—History and Services Provided

1) In what year did your program begin providing **outpatient mental health services for children and adolescents**?

   Year: _____

2) What is the age range your program uses to define "children and adolescents?"

   Age Range in Years for Children: _____

   Age Range in Years for Adolescents: _____

3) Is your program a Comprehensive Outpatient Programs (COPS) provider site?

   ☐ Yes ☐ No

4) What types of outpatient mental health services do you provide for **children and adolescents** in your program? Please include services provided by salaried, consulting and/or contract staff.

Service Type	**YES, program provides this service**	**NO, program does not provide this service**	**DON'T KNOW if program provides this service**
Assessment/Evaluation			
Individual psychotherapy			
Family Therapy			
Group Therapy			
Psychopharmacology			
Parent Skills Training			
Case Management			
Psychological Testing			
School-Based Services			
Home-Based Services			
Other (Please specify)_____			
Other (Please specify)_____			

5) Which of the following treatment models are used in your program's provision of **outpatient mental health services for children and adolescents**?

Treatment Model	**YES, this model is used by clinical staff in our program.**	**NO, this model is NOT used by clinical staff in our program.**	**DON'T KNOW if this model is used by clinical staff in our program.**
Cognitive Behavioral Treatment			
Psychodynamic Psychotherapy			
Behavior Management			
Interpersonal Therapy			
Play Therapy			
Parent Training			
Family Therapy			
Functional Family Therapy			
Multisystemic Treatment			
Multiple Family Groups			
Brief Treatment			
Other (Please specify):_____			
Other (Please specify):_____			

II. Program Capacity, Clients Served and Services Provided

1) How many unduplicated children and adolescents were seen for assessments/evaluations between January 1, 2002 and January 1, 2003?

_____ Children and Adolescents Seen for Assessments/Evaluations between January 1, 2002 and January 1, 2003

2) How many <u>active child and adolescent clients**</u> were enrolled in outpatient mental health services on January 1, 2003?

_____ Active Child and Adolescent Clients

**Active clients are individuals who meet ALL of the following criteria: 1) had completed assessment/evaluation; 2) had been admitted to this program for outpatient mental health services; 3) had been seen for mental health services at least once in the preceding 90 days; and 4) had <u>not</u> been discharged from treatment as of January 1, 2003.

3) Is the number of active clients in your program (from Question II.2 above) greater than, less than or about right for your program's capacity? What factors contribute to the match between the number of active clients and the capacity of your program? **Please select one response below and identify the top three factors which contribute to the match between the number of active clients and the capacity of your program.**

☐ Number of Active Clients is **Less Than** Program Capacity

☐ Number of Active Clients is **About Right** for Program Capacity

☐ Number of Active Clients is **Greater Than** Program Capacity

Top three factors contributing to the match between the number of active clients and the capacity of your program:

1) _____

_____

2) _____

_____

3) _____

_____

4) How many billable sessions of outpatient mental health service did your program provide for **child and adolescent clients** in the most recent 12-month period for which you have available information? If your program does not bill for mental health services, please provide information on sessions which would be considered billable, e.g. assessment/evaluation; individual, group, and family therapy; psychopharmacology.

Time period of sessions reported below:

FROM: _____/____/_____
Month Day Year

TO: _____/____/_____
Month Day Year

Total Number of Sessions:_____

If available, please provide session information in the table below:

Service Type	**Number of Sessions**
Assessment/Evaluation	
Individual Psychotherapy	
Psychopharmacology	
Group Therapy**	
Family Therapy**	
Collateral Contact	
Other-Please specify_____	
Other-Please specify_____	

**Group therapy is defined as it would be billed, such that each client in attendance of the group counts as 1 session. If 5 children attend a single group therapy session, then 5 billable sessions would be counted. Family therapy is defined as it would be billed, such that 1 session, regardless of the number of family members in attendance, is counted as a single session.

5) As of January 1, 2003, what percentage of your program's **child and adolescent outpatient mental health clients**' primary source of payment was… (Percentages should add to 100.)

Payment Source	**Percentage of Clients**
Medicaid	
Medicaid Managed Care	
Other - Please specify_____	
Unknown	

TOTAL: 100%

6) As of January 1, 2003, what percentage of the children and adolescents referred to your program's outpatient mental health services had no insurance?

_____ % of Children and Adolescents Referred to Your Program's Mental Health Services who Had No Insurance

6a) How does your program respond to children and adolescents referred to your program's outpatient mental health services when they do not have insurance?

_____

_____

_____

_____

_____

7) As of January 1, 2003, what percentage of the children and adolescents referred to your program's outpatient mental health services had insurance that your program does not accept?

_____ % of Children and Adolescents Referred to Your Program's Mental Health Services who Had Insurance Your Program Did not Accept

7a) How does your program respond to children and adolescents referred to your program's outpatient mental health services when they have insurance you do not accept?

_____

_____

_____

_____

_____

III. Client Characteristics

1) As of January 1, 2003, what percentage of the program's enrolled **child and adolescent outpatient mental health clients** were…
(Percentages should add to 100.)

Gender	**Percentage of Clients**
Male	
Female	
Unknown	

TOTAL: 100%

2) As of January 1, 2003, what percentage of the program's enrolled **child and adolescent outpatient mental health clients** were…
(Percentages should add to 100.)

Ethnic Background	**Percentage of Clients**
White (not of Hispanic origin)	
Black or African-American (Not of Hispanic origin)	
Latino/a or Hispanic	
American Indian	
Alaskan Native	
Asian or Pacific Islander	
Other - Please specify_____	
Unknown	

TOTAL: 100%

3) As of January 1, 2003, what percentage of the program's enrolled **child and adolescent outpatient mental health clients** primarily spoke…
(Percentages should add to 100.)

Primary Language	**Percentage of Clients**
English	
Spanish	
Other - Please specify_____	
Other - Please specify_____	
Unknown	

TOTAL: 100%

4) As of January 1, 2003, what percentage of the **parents, guardians and/or primary caregivers of the program's enrolled child and adolescent outpatient mental health clients** primarily spoke…
(Percentages should add to 100.)

Primary Language	**Percentage of Clients**
English	
Spanish	
Other - Please specify_____	
Other - Please specify_____	
Unknown	

TOTAL: 100%

5) As of January 1, 2003, what percentage of the program's enrolled **child and adolescent outpatient mental health clients** were…
(Percentages should add to 100.)

Age Range	**Percentage of Clients**
Under 5 years old	
5-12 years old	
13-17 years old	
18-21years old	
Unknown	

TOTAL: 100%

6) As of January 1, 2003, what percentage of the program's enrolled child and adolescent outpatient mental health clients were diagnosed with severe emotional disturbance (SED)?

_____ % of Child and Adolescent Clients Diagnosed with SED

7) As of January 1, 2003, what percentage of the program's enrolled child and adolescent outpatient mental health clients were in the foster care system (defined as a child under the custody of the child welfare system. This child may be in foster care, kinship foster care, therapeutic foster care or a group home)?

_____ % of Child and Adolescent Clients in Foster Care System

8) As of January 1, 2003, what percentage of the program's **child and adolescent outpatient mental health clients** had the following primary diagnoses… (Percentages should add to 100.)

Primary Diagnostic Category	Percentage of Clients
Attention Deficit Hyperactivity Disorder	
Other Disruptive Behavior Disorders (Conduct Disorder, Oppositional Defiant Disorder)	
Adjustment Disorder	
Mood and Anxiety Disorders (Bipolar Disorders, Depressive Disorders, Anxiety Disorders, including Posttraumatic Stress Disorder)	
Psychotic Disorders (Schizophrenia, Schizophreniform Disorder, Schizoaffective Disorder, Delusional Disorder, and Other Psychotic Disorders)	
Primary Substance Use Disorder	
Other- Please specify_____	
Other- Please specify_____	
Unknown	

TOTAL: 100%

9) As of January 1, 2003, what percentage of the program's child and adolescent outpatient mental health clients were diagnosed with co-occurring psychiatric disorders, not including substance use disorders?

_____ % of Child and Adolescent Clients Diagnosed with Co-Occurring Psychiatric Disorders

10) As of January 1, 2003, what percentage of the program's child and adolescent outpatient mental health clients were diagnosed with co-occurring psychiatric and substance use disorders?

_____ % of Child and Adolescent Clients Diagnosed with Co-Occurring Psychiatric and Substance Use Disorders

11) As of January 1, 2003, what percentage of the program's child and adolescent outpatient mental health clients were diagnosed with a co-occurring psychiatric disorder and mental retardation/developmental disability?

_____ % of Child and Adolescent Clients Diagnosed with Co-Occurring Psychiatric Disorder and Mental Retardation/Developmental Disability

12) What are the top five strengths of your program's provision of outpatient mental health services to address the presenting issues of your child and adolescent clients and their families?

1)_____

2)_____

3)_____

4)_____

5)_____

13) What are the top five challenges you face in your program's ability to address the needs of your child and adolescent clients and their families?

1)_____

2)_____

3)_____

4)_____

5)_____

IV. Aspects of Service Delivery

For each of the questions in this section, please provide average percentages over the past year.

1) Of the **children and adolescents** referred for outpatient mental health services in your program, what percentages are referred from the following sources…

Referral Source	**Percentage**
Parent(s)/Guardian	
Self	
School	
Day Treatment Program	
Inpatient Hospitalization	
Residential Program	
Child Welfare (ACS, foster care, prevention program)	
Legal System (police, judge, probation, etc.)	
Hospital Emergency Department	
Other- Please specify_____	
Other- Please specify_____	
Unknown	

TOTAL: 100%

2) Of the **children and adolescents** referred for outpatient mental health services in your program, what percentages are COPS referrals?

_____ % of Referred Children and Adolescents who are COPS Referrals

3) Of the **children and adolescents** referred for outpatient mental health services in your program, what percentages are turned away from services?

_____ % of Referred Children and Adolescents Turned Away from Mental Health Services in Your Program

3a) Of the children and adolescents who are **turned away** from mental health services in your program, what percentages are turned away for the following reasons?

Reason for Turning Away Referred Children and Adolescents	**Percentage among Those Who Are Turned Away from Mental Health Services**
Your Program Does Not Have Capacity	
Referred Child/Adolescent Could be Better Served by Another Agency/Program	
Referred Child/Adolescent Does Not Have Insurance	
Insurance of Referred Child/Adolescent Is Not Accepted by Your Program	
Other – Please specify_____	
Other – Please specify_____	
Unknown	

TOTAL: 100%

4) What percentage of children and adolescents referred for outpatient mental health services in your program attend their first scheduled assessment/evaluation appointment?

_____ % of Child and Adolescent Clients who Attend First Assessment/Evaluation Appointment

5) For children and adolescents who attend assessment/evaluation appointments, what is the average number of days between client or referral source initial contact with your program and the client being seen for an assessment/evaluation appointment for outpatient mental health services?

_____ Average Number of Days from Initial Contact to Assessment/Evaluation

6) How many sessions are involved in your program's standard assessment/evaluation protocol for outpatient mental health services for children and adolescent clients?

_____ Number of Sessions in Program's Assessment/Evaluation Protocol

7) What percentage of children and adolescents who begin assessment/evaluation for outpatient mental health services in your program, complete the process?

_____ % of Children and Adolescents who Complete Assessment/Evaluation Once Started

8) For child and adolescent clients who are admitted for outpatient mental health services, what is the average number of days between final assessment/evaluation appointment and first session to begin outpatient mental health services?

_____ Average Number of Days

9) After completion of assessment/evaluation process, what percentage of scheduled outpatient mental health service appointments with child and adolescent clients are **not attended** by the client?

_____ % of Scheduled Appointments with Child and Adolescent Clients which are **NOT ATTENDED** by the Client

10) For child and adolescent clients who are admitted for outpatient mental health services, please indicate the percentage of clients who attend 0, 1, 2-7, or more than 8 sessions prior to discharge.

Average Number of Sessions	Percentage of Clients
0	
1	
2-7	
8 or more	

TOTAL: 100%

11) When a child or adolescent is discharged from outpatient mental health services in your program, what percentage of the discharges are due to the following reasons?

Reason for Discharge	Percentage of Clients
Service plan goals attained	
Child/Family stopped attending services	
Other-Please specify_____	
Other-Please specify_____	
Unknown	

TOTAL: 100%

12) What services do your child and adolescent clients need, but cannot get, either from your program or elsewhere?

Type of Service	Unable to Access This Service	Reason for Lack of Access, if Known
Medical		
Psychological Testing		
Educational		
Vocational		
Financial		
Legal		
Family		
Aftercare		
Mentoring Program (Big Brother, Big Sister)		
Afterschool Activities		
Inpatient Treatment		
Residential Care Facility		
Day Treatment		
Transportation		
Other-Please specify_____		
Other-Please specify_____		
Other-Please Specify_____		

12a) Of the services you identified above, how would you **rank the top three** services your child and adolescent clients need but cannot get?

1)_____

2)_____

3)_____

V. Program Staffing

Please use the table below to answer these four questions. For each of these questions, please include only the hours during which outpatient mental health services for children and adolescents were provided.

1) How many paid full-time equivalent* **salaried**** staff members providing mental health services to children and adolescents did your program have **budgeted** in each of the following categories on January 1, 2003?

2) How many paid full-time equivalent* **salaried**** staff members providing mental health services to children and adolescents did your program **actually have** in each of the following categories on January 1, 2003?

3) How many full-time equivalent* **contract** staff** and consultants providing mental health services to children and adolescents did your program have **budgeted** in each of the following categories on January 1, 2003?

4) How many full-time equivalent* **contract** staff** and consultants providing mental health services to children and adolescents did your program **actually have** in each of the following categories on January 1, 2003?

STAFF TYPE	**1.) Budgeted Number of Full-Time Equivalent Staff on Payroll**	**2.) Actual Number of Full-Time Equivalent Staff on Payroll**	**3.) Budgeted Number of Full-Time Equivalent Contract/ Consulting Staff**	**4.) Actual Number of Full-Time Equivalent Contract/ Consulting Staff**
Physicians (MD/DO, psychiatrists)				
Professional Clinical Staff (Master's level and above)				
Paraprofessional Clinical Staff				
Other Clinical Staff				
Total				

*Full-time equivalent equals one staff member working at least 35 hours per week. If any staff worked in more than one staff category listed, please put them in the one category in which they worked the most during the week ending January 10, 2003.

**Salaried and contract staff are differentiated as follows: salaried staff are permanent staff who are paid regardless of clients' attendance at sessions, whereas contract staff are considered "contracted," 'temporary," "per diem," "fee-for-service," or "consulting" providers who are typically paid on an hourly basis.

5) What was the turnover rate of direct clinical staff, i.e. what percentage of your program's direct clinical staff in your outpatient mental health services for children and adolescents ended employment with your program, between January 1, 2002 and January 1, 2003? (Please use the following formula to calculate this response for salaried staff and contract staff: Total Number of Salaried or Contract Individuals who Ended Employment with Your Program January 1, 2002 to January 1, 2003/Total Number of Salaried or Contract Individuals Employed January 1, 2002 to January 1, 2003.)

____ Percentage of Program's Direct Clinical **Salaried** Staff Providing Outpatient Mental Health Services for Children and Adolescents who Ended Employment between January 1, 2002 and January 1, 2003.

____ Percentage of Program's Direct Clinical **Contract** Staff Providing Outpatient Mental Health Services for Children and Adolescents who Ended Employment between January 1, 2002 and January 1, 2003

6) How many of your program's staff who provide direct clinical outpatient mental health services for children and adolescents have the following language abilities?

Skills	**Number of Clinical Staff**
Monolingual English	
Fluency in English and Spanish	
Fluency in English and Creole	
Other Language Ability - Please specify_____	
Other Language Ability - Please specify_____	

TOTAL: _____

7) As of January 1, 2003, what percentage of the program's child and adolescent outpatient mental health clinical staff were…
(Percentages should add to 100.)

Ethnic Background	**Percentage of Clinical Staff**
White (not of Hispanic origin)	
Black or African-American (Not of Hispanic origin)	
Latino/a or Hispanic	
American Indian	
Alaskan Native	
Asian or Pacific Islander	
Other - Please specify_____	
Unknown	

TOTAL: 100%

VI. Other Comments/Input

Please provide any additional comments in the space below.

(Please attach additional pages as needed. Please identify question number in attached pages.)

Thank you very much for your participation in this needs assessment regarding outpatient mental health services for children and adolescents in the Bronx.